Alzheimer Scotland
Action on Dementia

The Scottish Government
Riaghaltas na h-Alba

Allied Health Professionals Delivering Integrated Dementia Care:

Living Well with Community Support

Carol, David and Peter from the Scottish Dementia Working Group with staff-member Wendy Rankin (second from right) and Elaine Hunter (background) at the launch of the second report in this series in September 2014.

David from the Scottish Highlands living well with dementia.

Foreword: Jim Pearson, Deputy Director of Policy, Alzheimer Scotland

Jim Pearson is the Deputy Director of Policy, Alzheimer Scotland. He has a particular interest in promoting the human and other legal rights of people living with dementia and was involved in writing the Charter of Rights for People with Dementia and their Carers. The charter informs all Alzheimer Scotland public policy work and underpins all aspects of Scotland's national dementia strategy and other strands of work. He is also on the board of Alzheimer Europe.

Alzheimer Scotland is working with a wide range of partners to deliver transformational change across Scotland's health and social care systems to ensure the highest quality of care, treatment and support for every person living with dementia, throughout the illness, and in every setting. Evidence shows that by doing so we can delay people moving to care homes, and reduce the need for unplanned hospital admissions. By reducing the need for such costly crisis interventions we can deliver better personal outcomes for the growing number of people living with dementia, including supporting them to live well at home for longer.

Alzheimer Scotland's 5 Pillars Model of Post Diagnostic Support, the basis for the Scottish Government's post diagnostic support guarantee, and 8 Pillars Model of Community Support are important strands of this change programme to support people from diagnosis throughout the illness. The 8 Pillars Model, which is currently being tested in several sites as part of Scotland's National Dementia Strategy, builds on the one year post diagnostic support guarantee and sets out a blueprint for coordinated and integrated community support for people living with dementia to enable them to live well in the community for longer.

Allied Health Professionals (AHPs) have a vital role to play in supporting this work by providing skilled, person-centred, health, education and social care interventions which can help people with dementia and their carers to live well in their own communities.

In particular, AHPs have a unique spectrum of professional skills which are crucial in delivering a range of non-pharmacological therapeutic interventions which tackle the symptoms of dementia, help people cope better and improve their quality of life. This

'AHPs have a unique spectrum of skills which can help people with dementia cope better and improve their quality of life.'

publication showcases practice examples which clearly demonstrate the wide ranging and innovative contributions that AHPs can make to delivering better personal outcomes for people with dementia and their carers which meet their individual aspirations.

As an organisation, Alzheimer Scotland has been delighted to work closely with the AHP community in taking forward the change needed to ensure the highest quality of care, support and treatment for every person living with dementia in the future. I welcome this report: it not only highlights the energy and creativity of AHPs, but also clearly illustrates the vital contribution they are making to support this change. ■

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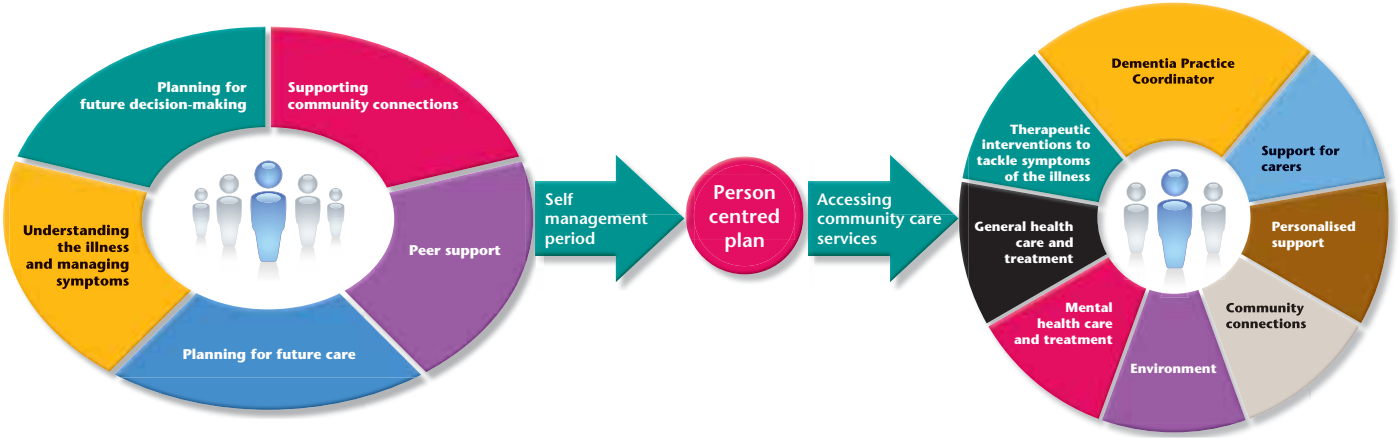


Foreword: Irene Oldfather, Chair, National Dementia Carers Action Network

The Alzheimer Scotland National Dementia Carers Action Network (NDCAN) was set up three years ago to ensure that the policy landscape was influenced by the lived experience of carers. It is a pleasure to write a foreword for this report on behalf of NDCAN, especially given the role that AHPs play in supporting carers at all stages of the caring experience. AHPs have long been recognised by carers as not only providing that "helping hand" along the way but giving very valuable and practical advice on matters such as nutrition, hydration, continence and exercise – the simple things which can keep people well and connected. Indeed in terms of the 8 Pillar Model of support, much of what we would identify as therapeutic intervention would be supported by our AHPs.

It is difficult to overestimate the importance of therapeutic intervention for families living with dementia. Having been a carer to my mum, I firmly believe that it was keeping her active, engaged and grounded in her family and community that ensured that she lived as well as she could, for as long as possible. I never fail to be amazed by the resilience that families living with dementia show and also the willingness that they have to learn how to get the best out of every single day.

While there are no two paths the same, learning from the experience of others can shed light on days which otherwise seem fraught with difficulty.

This booklet will be an invaluable resource. It provides many examples of how AHPs in different ways support families and describes how we can make every day, for people with dementia and their families and carers, more meaningful. Thanks so much to the dedicated teams of AHPs across Scotland who work with us as carers to make every single day count. ■

Members of NDCAN signing the Glasgow Declaration at the Alzheimer Europe Conference 2014. *Left to right:* Lorna Walker; Ann Pascoe; Myra Lamont; Amanda McCarren; Irene Oldfather (Chair); Jeanette Maitland.

Foreword: Geoff Huggins, Scottish Government

Geoff Huggins is the Acting Director of Health and Social Care Integration, Scottish Government. Geoff has key responsibility in the directorate for Primary Care Services, Dentistry, Social Care Services, Mental Health Services and he also leads on Scotland's Dementia Strategy for Scottish Government.

Scottish Government made dementia a national priority in 2007 and we now have our second dementia strategy in Scotland. We have also convened an international meeting to discuss opportunities and priorities for sustainable international and cross-sectoral collaboration where we identified opportunities for international collaboration. In October I signed the Glasgow Declaration which calls for the creation of a European Dementia Strategy that commits to fully promoting the rights, dignity and autonomy of people living with dementia.

In writing and delivering on our commitments in Scotland we have built upon our strong partnership approach in implementing and developing dementia policy. We have benefited from the significant expertise of Alzheimer Scotland and others along with people living with dementia and their carers who are continuing to take a full role in helping to improve services both nationally and locally.

Alzheimer Scotland's policy paper "Delivering Integrated Dementia Care: The 8 Pillars Model of Community Support" proposes an integrated model to address these issues and we are piloting this model in five areas of Scotland to gather evidence about the effectiveness of the model.

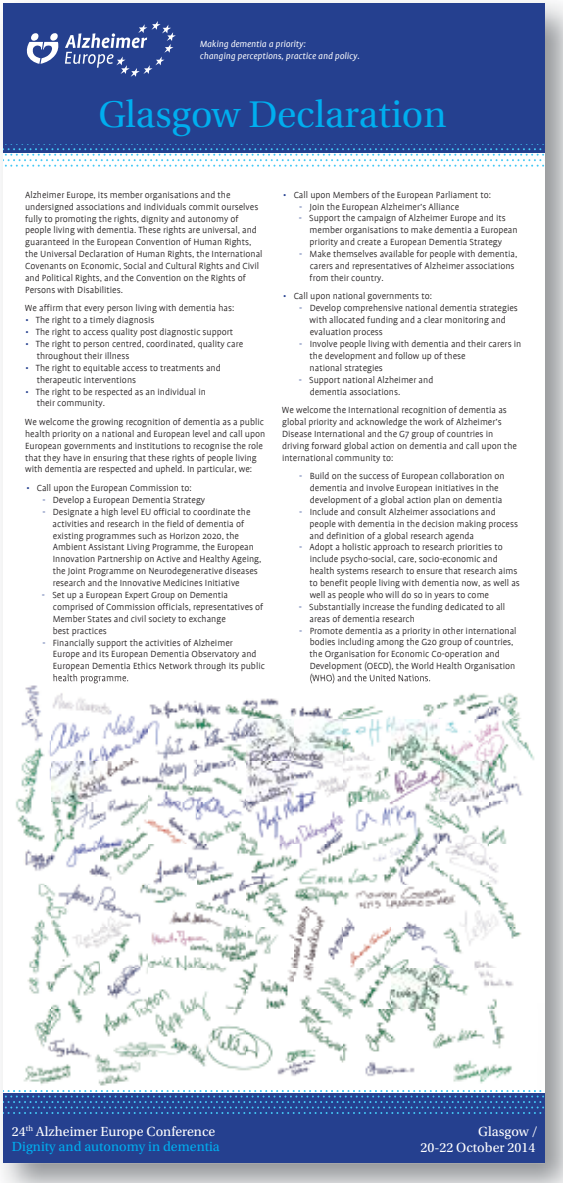
To support this work we commissioned Alzheimer Scotland to produce an evidence based policy document that will be available next year, that will outline the contribution of the AHPs to the 8 Pillars Model as well as their contribution to the key messages in the dementia strategy. The practice examples in this publication from only 14 of these professionals demonstrates many great examples of where we are getting it right: from dietitians working with carers, physiotherapists working in partnership with Alzheimer Scotland in the football reminiscence project and occupational therapists implementing the evidence based tailored activity programme.

I would encourage you all to read this publication, consider how we can spread

'Remember to keep working in partnership with people living with dementia and carers and ask the question "what matters to you".'

and sustain the good practice examples and for the allied health profession community to be ambitious in writing their policy document to enable them to be integral to the transformational changes taking place not only in Scotland but in the UK, Europe and internationally. Also remember to keep working in partnership with people living with dementia and carers and ask the question "what matters to you". ■

Geoff Huggins (left) signing the Glasgow Declaration accompanied by (left to right) John Laurie, Jeanette Maitland, Henry Simmons and Heike von Lützau-Hohlbein. The declaration, which was unveiled at Alzheimer Europe's conference in Glasgow in October, is shown in full on the right.



Alzheimer Europe

Making dementia a priority: changing perceptions, practice and policy.

Glasgow Declaration

Alzheimer Europe, its member organisations and the undersigned associations and individuals commit ourselves fully to promoting the rights, dignity and autonomy of people living with dementia. These rights are universal, and guaranteed in the European Convention of Human Rights, the Universal Declaration of Human Rights, the International Covenants on Economic, Social and Cultural Rights and Civil and Political Rights, and the Convention on the Rights of Persons with Disabilities.

We affirm that every person living with dementia has:

- The right to a timely diagnosis
- The right to access quality post diagnostic support
- The right to person centred, coordinated, quality care throughout their illness
- The right to equitable access to treatments and therapeutic interventions
- The right to be respected as an individual in their community.

We welcome the growing recognition of dementia as a public health priority on a national and European level and call upon European governments and institutions to recognise the role that they have in ensuring that these rights of people living with dementia are respected and upheld. In particular, we:

- Call upon the European Commission to:
  - Develop a European Dementia Strategy
  - Designate a high level EU official to coordinate the activities and research in the field of dementia of existing programmes such as Horizon 2020, the Ambient Assistant Living Programme, the European Innovation Partnership on Active and Healthy Ageing, the Joint Programme on Neurodegenerative diseases research and the Innovative Medicines Initiative
  - Set up a European Expert Group on Dementia comprised of Commission officials, representatives of Member States and civil society to exchange best practices
  - Financially support the activities of Alzheimer Europe and its European Dementia Observatory and European Dementia Ethics Network through its public health programme.
- Call upon Members of the European Parliament to:
  - Join the European Alzheimer's Alliance
  - Support the campaign of Alzheimer Europe and its member organisations to make dementia a European priority and create a European Dementia Strategy
  - Make themselves available for people with dementia, carers and representatives of Alzheimer associations from their country.
- Call upon national governments to:
  - Develop comprehensive national dementia strategies with allocated funding and a clear monitoring and evaluation process
  - Involve people living with dementia and their carers in the development and follow up of these national strategies
  - Support national Alzheimer and dementia associations.

We welcome the International recognition of dementia as global priority and acknowledge the work of Alzheimer's Disease International and the G7 group of countries in driving forward global action on dementia and call upon the international community to:

- Build on the success of European collaboration on dementia and involve European initiatives in the development of a global action plan on dementia
- Include and consult Alzheimer associations and people with dementia in the decision making process and definition of a global research agenda
- Adopt a holistic approach to research priorities to include psycho-social, care, socio-economic and health systems research to ensure that research aims to benefit people living with dementia now, as well as well as people who will do so in years to come
- Substantially increase the funding dedicated to all areas of dementia research
- Promote dementia as a priority in other international bodies including among the G20 group of countries, the Organisation for Economic Co-operation and Development (OECD), the World Health Organisation (WHO) and the United Nations.

24th Alzheimer Europe Conference
Dignity and autonomy in dementia

Glasgow / 20-22 October 2014

Introducing the role of Dementia Practice Coordinator in the Highlands

Lynda Forrest is a specialist occupational therapist based in NHS Highland, one of 5 boards selected to test out the delivery of the 8 Pillars Model of Community Support. Lynda is part of a small team based in East Sutherland, where she and her colleagues have been finding innovative ways to deliver integrated dementia care to remote and rural communities.

I am based in a community mental health team in one of the most northern regions of the Scottish Highlands.

My role includes a secondment to the Scottish Government as project manager of the 8 Pillars Model test site in East Sutherland. This model introduces the role of a Dementia Practice Coordinator (DPC), a skilled practitioner who coordinates a full range of social and health care support for people living with the later stages of dementia. I have also been selected to work on services as a Dementia Practice Coordinator.

Of course there are challenges associated with delivering three roles at once, especially in such a remote and rural area, but there are also huge benefits. Our clinical experience of working with people living with dementia can be used to directly influence how we plan our services for people with dementia. This means we are delivering on what people tell us they value most.

A great example of this is illustrated by the links we established with the Up and About In Care Homes project (for more information, see Lynn Flannigan's interview on page 30), which aims to reduce the number of falls among older adults across Scotland. As Dementia Practice Coordinator, I worked with the AHPs from Up and About to produce a methodology which mixed both of our projects together, and tested this to see the effectiveness of the idea. We worked with a gentleman in a local care home who had been falling on average four times a month. Since applying Up and About's principles with the overview of my Dementia Practice Coordinator role, he hasn't fallen at all. This shows the meaningful improvements that the 8

Pillars Model may hold for people living with dementia, and can be attributed to the global, outcome-focused approach shared by all AHPs.

I am now aiming to employ similar methodology using the Community Falls Prevention project, to modify the falls risk for people who are living with later stages of dementia in their own homes.

The 8 Pillars Model emphasises the role that communities can play in supporting people with dementia. In Sutherland, a local charity Dornoch Firth Group provide a service called 'Good Morning Sutherland' that offers phone calls to reassure and check in on vulnerable adults living in the area. We applied our Dementia Practice Coordinator ethos to this service, and now support the charity in contacting people with dementia. A volunteer will call the person with dementia in the morning, remind them of the date, events they might have on that day, and if they need to take any medication. This simple service offers a far more efficient, person-centred use of our resources, compared with the traditional solutions of employing home care services.

I have found that the 8 Pillars Model of Community Support is a fantastic way for us to integrate and develop our services across the area. Our communication with other community partners – including charities, social work, GPs and other AHP colleagues – continues to improve simply because we are using a holistic model of care. Sharing an office with the Dementia Link Worker and the Community Psychiatric Nurse develops our routine clinical discussions on how we are delivering dementia care, and helps us to identify and agree areas for development. This whole-system approach has helped everyone understand what we're trying to achieve, and people can really see benefits for people living with dementia and for staff. ■

'The 8 Pillars Model emphasises the role that communities can play in supporting people with dementia.'

Lynda Forrest photographed by Andrew Pascoe, a person with dementia. The landscape photo of Helmsdale (facing page) was also taken by Andrew.

Spearheading a national model of integrated health and social care

Sandra Shafii, AHP Consultant, is the NHS Lanarkshire lead for the 8 Pillars Model of Community Support test site in North Lanarkshire. She has a national role that includes a specific focus on promoting activity, participation and the environment, including developing dementia-friendly communities.

Five areas across Scotland have been selected as test sites for the 8 Pillars Model of Community Support. The model is based on the integration of health and social care and is for people living with dementia and their carers who have increasing need for help and support to continue to live well in their community. Over the next year (until January 2016), the five test sites will investigate how the model can improve the experience of living with dementia in the community. Our test site is being run in partnership with NHS Lanarkshire, North Lanarkshire Council, Alzheimer Scotland and others.

The Dementia Practice Coordinator is a new role that has been defined in the 8 Pillars Model of Community Support. We have seven coordinators in our North Lanarkshire test site, two of which are from occupational therapy backgrounds and I am the lead for NHS Lanarkshire.

Dementia Practice Coordinators are named, skilled practitioners who coordinate and lead the care and support for a person with dementia and their carer. I believe that Allied Health Professionals (AHPs) are ideally suited to work within this model. We have always worked in a person centred way, seeing the person in the context of their citizenship and as a member of their personal and social community. AHPs have always worked across health and social care; the two core aspects that the 8 Pillars Model brings together. In my lead role, I have been supporting development, generating new ideas, developing research ideas, piloting projects and working in partnership for the test site.

We recently published and launched our report on our dementia friendly community work and presented our findings to date from working with our black and minority ethnic (BME) communities and dementia at the 2014 Alzheimer Europe conference. Our BME and faith communities study has examined the perspectives of several BME groups – East Asian, Polish and Congolese communities – by asking about their culture's understanding and attitude towards dementia. The findings were very varied and informative and we are continuing to meet with our other communities to find out more. Some cultures don't have a word for the condition and stigma surrounds it, whereas others are aware of dementia but not of the support available to them. We will use this work to tailor our approach

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to dementia care for these communities in the future.

Another of our pieces of research explores the link between GPs and people with dementia. The research looks at the perspectives of everyone with an interest in the 15 month review process, where GPs follow up people in primary care after they receive their diagnosis. We are interested in the expectations that GPs, people living with dementia and their carers have of each other and of the review process and how the 8 Pillars Model of Community Support can help. This research is being conducted in association with the Joseph Rowntree Foundation.

A key part of my role as the NHS Lanarkshire lead for this work is evaluation. This includes examining the new systems and structures which surround the Dementia Practice Coordinator role, reflecting on these, and suggesting service improvements. One of our goals is to identify the best way of ensuring dementia care coordination happens across the complexities of health and social care, the implications of embedding the model into future practice and how the model can support the person and the carer to have the best quality of life supported by the best quality of care. Evaluation will also include exploring the other pillars and how they help delivery of community support. I update my health colleagues on our findings and thoughts through national group learning sessions, as well as meetings with my AHP Dementia Consultant colleagues and others.

Our North Lanarkshire test site shows our commitment to providing a solid foundation for excellence in delivering care for people living with dementia. As our seven Dementia Practice Coordinators are drawn from across mental health services, social work services and primary care, we are in a perfect position to see how the model will function. We are excited to introduce the 8 Pillars Model, evaluate it and develop it in the coming year. ■

Alzheimer Scotland's network of Dementia Resource Centres, like the one in Kilmarnock (pictured below), are helping to 'bring dementia to the high street' and are playing an important role in developing dementia-friendly communities.

Personalising care in the community for people with dementia and their carers

Gail Hogg is an occupational therapist based in NHS Fife. Gail and her colleague, healthcare support worker Liz Davidovic, have implemented several successful community projects that support people with dementia and their carers through cognitive stimulation therapy, group support and life story work.

Gail: I qualified in 1999 as an occupational therapist, and have worked with the Older Adult Mental Health Service at Whyteman's Brae Hospital for the last 10 years. Most of my experience has involved working with people with dementia. Three years ago I received NES training in cognitive stimulation therapy (CST), which informed my work on our CST group. I went on to win the Therapist of the Year Award at the Scottish Health Awards 2013 for my work with this group and for developing a further bespoke CST carers group.

The CST group runs for 14 weeks at the Occupational Therapy department in Whyteman's Brae Hospital in Kirkcaldy, and works with people who have early onset dementia to the later stages of dementia. Each weekly session covers a different theme, including physical activities like bowls or cognitive activities like pop quizzes or crosswords. We begin by introducing everyone and engaging them with daily reality through the newspapers. Then we do a warm-up game, and finally move on to the main reminiscence activity.

While our CST sessions were very successful, they made us aware of a need for a new group, which focused on carers. We found that carers would often come to Liz and me during the CST group to ask about how to deal with challenges they face in their loved one's dementia, or how they could improve their caregiving. We decided to expand our informal advice in these situations into a full carers' support meet-up, which runs in tandem with the CST group once a month instead of weekly. The project has been a success, and with Liz's input, we have managed to really individualise the care in this group.

We run between five or six carers' support groups during the 14 week CST course, and the focus in these sessions is around informal and personalised care advice. We will ask them about what stage the dementia is at; what the person's needs are now; and what their future needs might be. Feedback for these groups has been very positive, some people saying that they felt lost at sea without it.

Within this work there have been opportunities for partnership working. Liz went on a placement with Alzheimer Scotland and learnt about all the services they provide, and now she liaises with many of their staff to enhance support and get better information for carers.

Liz Davidovic (left) and Gail Hogg.

Gail with her Therapist of the Year Award, which she received in 2013. (Picture courtesy of Fife Free Press.)

Alzheimer Scotland staff often attend the carers' group to offer individual support to members of the group.

Liz: As well as personalising care with our two parallel groups, we have used life story work (LSW) to individualise care for people with dementia in the community. I have worked on many LSW projects throughout my 13 years with the Older Adult Mental Health Service.

We use LSW to get a sense of the individual by using personal timelines and multimedia prompts to explore their life history. The end result is a booklet with their own personal timeline and images. It can be a rewarding experience which reinforces a person's sense of identity, and in turn their self-esteem and confidence.

We prefer to do life story work in the home environment, where the person is surrounded by familiar items and feels comfortable. Family members and carers can be included in this context. They are normally more relaxed and we're able to engage with them more effectively because of this, lifting mood and reducing anxiety and stress.

These three core aspects of our mental health services – the CST group, the carers' group and the use of LSW – ensures that at every level our care is personalised and bespoke. ■

A CST group at Whyteman's Brae. (With thanks to the members of the group for giving permission for this picture to be published.)

'**Tulip fields**'.

'Our cognitive stimulation therapy group works with people who have early onset dementia to the later stages of dementia.'

Supporting people with dementia to eat well

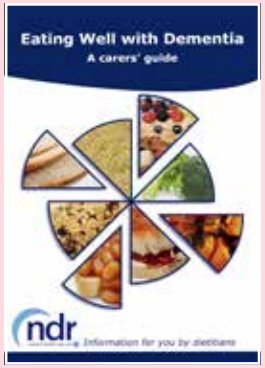
Gillian McMillan is a specialist dietitian working in NHS Lanarkshire, focusing on adult and older adult mental health. She has helped create and distribute an innovative dietary guide called 'Eating Well with Dementia: A carers' guide'.

I have been in post with the mental health service in Wishaw for ten years, and we have found that the issues which surround eating and dementia are very complicated. A person may have challenges with remembering to eat or drink, having a varied enough diet, or dealing with changes in their sense of taste. When someone is referred to our service we carry out a dietary assessment, which looks at a range of factors such as physical and mental health, weight history, social influences and diet. Based on this, we provide practical dietary advice on how the person and their carer can address these issues.

We spent some time developing a booklet called 'Eating Well with Dementia: A carers' guide'. Our goal was to pre-empt the problems we commonly find at assessment – for example stress experienced by carers who are trying to encourage a person to eat well – by making information more accessible to carers at an earlier stage. This has the potential to improve dietary care in the community, as the guide contains advice that carers can personalise to their needs. It is written in a 'question and answer' format, answering questions surrounding nutrition and dementia at moderate to advanced stages. In conjunction with NDR-UK we consulted Alzheimer Scotland, people with dementia, carers and health care professionals when producing the guide to ensure it was as relevant and accessible as possible.

The guide can help prevent some of the most common dietary issues from arising, as well as helping people with dementia manage any dietary problems they may have later in their journey. The booklet covers topics like eating habits; nutrition; hydration; constipation; and mouth care. Simple tips are offered in each section, for example splitting up portions to prevent overeating or offering a drink instead of more food. Carers have said that these simple changes can make a big difference.

One of our primary goals with the guide was to demystify dementia by highlighting many eating issues which carers may not be aware of. For example, improving the light in the room where the person eats or removing clutter and distractions from their table can make mealtimes easier for them and reduce stress for the carer. The booklet provides advice on other issues like change in taste. Some people with dementia have a tendency to develop a taste for sweet foods which can become a concern for carers. However, with a little



The resource that Gillian helped develop.

tweaking, a sweet diet can still be a varied and balanced one.

The guide has been a great success in sharing dietary information with carers across Scotland, and is available on the Scottish Government website (see page 36 for web link). In addition, it has led onto a community cooking skills group in Lanarkshire based on a previously successful pilot in NHS Tayside which provides active support for carers (see page 24 – Elizabeth Stewart). This is aimed at partners of people with dementia who might not have been the primary cook in the household before diagnosis. We help these carers maintain their independence by learning how to cook simple foods like casseroles, soup or pasta, and the essentials of kitchen hygiene. This project was provided through local voluntary organisations, Healthcare Improvement Scotland, and the Lanarkshire Community Food and Health Partnership.

Our approach to dietary care touches on several core aspects of the 8 Pillars Model of Community Support, ensuring that support for carers and people with dementia is personalised and community-based. ■

'The dietary guide we produced is written in a 'question and answer' format, answering questions surrounding nutrition and dementia at moderate to advanced stages.'

Gillian McMillan (right) photographed with a colleague.

Using music therapy in dementia care

Emma Maclean is a lead music therapist based within NHS Lothian. Her work focuses on engaging people with dementia in a therapeutic musical relationship.

I have been in post at Herdmanflat Hospital since 2004, and in 2013 I became the music therapy team lead. The team consists of myself and one other music therapist. Within our support for adult and older people's mental health, one of our first goals was to see where our service could fit into care for people living with advanced dementia where more help and support is required, as outlined in the 8 Pillars Model, or in cases of advanced dementia.

Music therapy normally takes place in weekly sessions, which I deliver individually in a private room on a ward. I have also started a monthly group with an occupational therapy assistant that encourages participants to use instruments in active music-making, which can enable more social interaction. This therapeutic approach uses a mixture of familiar songs and improvisation, in contrast to other music groups, such as sing-alongs and concerts on the ward, which use recorded music or performance. My music therapist colleague is aiming to set up a new resource for people with dementia living in the community, which is forthcoming.

Music therapy itself is an active technique that focuses on giving the person a voice within music. We choose what to play based on what we already know about the person and what they bring to the session. For example, they may hum a tune, tap a rhythm or play something on an instrument, which can be incorporated into what we are playing together.

Playing instruments and engaging in music can provide many benefits for people with dementia. It can stimulate abilities and encourage the maintenance of motor skills. Singing and humming can often reach different parts of the brain. When done in groups, it can keep the brain active and greatly increase social activity and awareness. Music therapy is a psychological therapy which can improve functioning in a similar way to cognitive stimulation therapy, but without the need to use language.

When a person is referred to us, we find out as much about them as possible. Their family or carers will tell us about what they find challenging. Resources like the Playlist for Life are used by staff on the ward to talk with families and find out what music may be meaningful to the person. The music we make in our sessions may be partly informed by this research, but also develops fluidly, based on what the person and the group does in the moment.

I work with one woman who has a history of playing the violin, which she alerted us to after a group session. Now I bring a violin in with me and simulate the music she liked so we can tie her therapy in with her life history. She sings along with familiar songs and sometimes plays the chime bar: a tuned metal bar used for simple musical interaction. This woman often has a low mood as a result of her dementia, but in our sessions the movement between conversation and music appears to improve her mind-set.

The space in which we provide our therapy is tailored to be a dementia friendly environment. We make sure everything is accessible and that there aren't any physical barriers, so that people who may have problems with motor skills can easily get involved. The groups are set up in a circle, so that everyone can see everyone. We offer or share instruments depending on skills and motivation, and ensure that people are free to come and leave as they wish.

In providing a musical mental health service which is both therapeutic and personalised, our care links in with several parts of the 8 Pillars Model of Community Support. ■

'Playing instruments and engaging in music can provide many benefits for people with dementia. It can stimulate abilities and encourage the maintenance of motor skills. When done in groups, it can keep the brain active and greatly increase social activity and awareness.'

Helping people with dementia to stay active in their homes

Jenny Reid is an AHP Dementia Consultant based in NHS Lothian. Over the last two years she has piloted a unique evidence-based programme, developed in the USA, to help carers engage people with dementia in enjoyable activities.

When I started in post in 2011, I was given a national remit to focus on early interventions and supported self-management. I decided that one of these focuses would relate to activities, as this is a key aspect of caring for people who have a diagnosis of dementia which can reduce stress and enhance wellbeing for the person as well as their carer.

In 2012 we made contact with two American academics who came and provided NHS staff across Scotland with training in the Tailored Activity Programme (TAP). This enables carers and people with dementia to maintain or resume activities they enjoy. We have historically had a lot of information to share with carers, but less in the way of direct personal support for them, and TAP fills this gap. We wanted to help carers find new, creative ways of caring that can be enjoyed by themselves as well as the person they care for.

Professor Laura Gitlin (Johns Hopkins School of Nursing) and Associate Professor Catherine Piersol (Thomas Jefferson University) led the training element of the national TAP pilot in Scotland. This involved an intensive three day course attended by 24 occupational therapists from six NHS Scotland health boards. The occupational therapists learned about all the techniques they needed to use TAP, so they were ready to start delivering it in practice.

Alison Groat (left) and Joanne Payne (right) taking part in TAP training.

One of TAP's core ideas is the 'activity prescription'. When an occupational therapist first visits a person with dementia, they will identify what activities are important to them, along with their level of ability and what might prove challenging for them. The therapist then writes a 'prescription' for the carer, explaining how to introduce these activities and help the person achieve them. The therapists were trained to produce these prescriptions and as part of the accreditation process, with Laura and Cathy checking they fitted with the TAP principles.

One occupational therapist helped a gentleman whose carer was concerned that he had become quite passive and it was hard to engage with him. Before his diagnosis, the man had been interested in

ornithology, and would sit in his favourite chair with a bookcase beside him and a TV, on which he watched footage of wild birds. Since his diagnosis, he had looked at these films less and less.

The occupational therapist gave the man's wife a TAP prescription which detailed ways of getting him more involved in his hobby again. This included moving his birdwatching books so they would be at his eye level, and changing the position of his TV. Before she had even made these changes, the prescription helped the carer understand how to support him to continue with these activities that he had previously enjoyed.

TAP prescriptions aren't simply instructions on how to assist a person with dementia to be more active. They also provide helpful direction on things like what times of day may be good to engage the person in order to ease stressed behaviour. The occupational therapist would also link these strategies to other routine activities to help the carer identify ways that activities can be made more enjoyable and less stressful. The aim is to support the carer in the good work they do, and to help them identify new techniques to overcome difficult situations.

We are currently exploring ways of rolling out TAP cross the country. I am also delighted to see an Alzheimer Scotland PhD Studentship next year, advertised by Alzheimer Scotland and Queen Margaret University. The focus of this PhD will be on the tailored activity programme and will offer us the much needed research to enhance our clinical practice. ■

The TAP group during training. Front row: Catherine Piersol, Laura Gitlin and Jenny Reid.

Supporting speech and language therapy in the community

Joy Harris is a speech and language therapist based within a community mental health team in NHS Lothian. She leads a team improving the wellbeing of people with dementia in the community through speech and language therapy, publications and joint working.

I've been in this role now for nearly 20 years, and my team works with people at every stage of the dementia journey. Our work mainly focuses on one-to-one, tailored sessions. There are three main ways in which we provide support: communication; eating, drinking and swallowing; and providing advice sheets.

Communication is one of the most important aspects of speech and language therapy, and is always personalised. For instance, one of our main techniques is developing individualised vocabulary books. These are small booklets of words which will be particularly helpful or important for the person in their everyday lives. Examples may include place names, objects or people they will frequently encounter. One woman we supported had mid-stage dementia that affected her communication significantly. She wanted to continue attending an exercise class, so we produced a vocabulary booklet relevant to the class and gave her a card which she could show people to help explain the impact of her dementia. We also visited her class to talk them through her difficulties with communication.

As well as supporting the individual themselves, working with their carer can sometimes be the most important aspect of speech and language therapy in the later stages of care. Our work on this ties in with the 8 Pillars Model of Community Support, as it involves helping carers understand the role they can play in aiding communication. Speech and language therapists often say that the listener actually has to do more work than the person who is trying to get something across. They have to ask the right kinds of question or prompt the person in the right way to avoid them becoming confused. For instance, asking questions which offer clear choices rather than those that require a long or complex answer can be a great help. Simple changes like these can reduce stress and improve communication for a person with dementia.

Eating, drinking and swallowing is the other side of speech and language therapy, and we often provide advice to carers or care staff on how to support a person with dementia during mealtimes. This mainly becomes an issue in advanced dementia. We can help carers to manage eating and drinking safely, so that a person isn't at risk of coughing or developing a chest infection. For example we provide advice on posture, altering the texture of food so it's easier to swallow,

or environmental factors like noise or low light. We can make a real difference by flagging up factors like these to carers.

Distributing advice and information is the third core part of what we do for service users and colleagues. We have a set of advice sheets which we have produced for people who use the service, enabling them to maintain the advice we give them when they get home. The sheets provide written examples of techniques to aid communication and eating, drinking and swallowing.

We have developed a leaflet that explains how speech and language therapy connects with people with dementia. This was produced in partnership with Alzheimer Scotland and the Royal College of Speech and Language Therapists, and can be used by people with dementia, their carers, family, or care staff. It explains what we do, and will be distributed across the country in GP practices, through Alzheimer Scotland services, and in any environment where speech and language therapists are working. This combination of take-home information, tailored advice and one-to-one support is making a real difference to improving the lives of people with dementia. ■

Giving Voice | Giving Voice for people with dementia

Alzheimer Scotland

Speech and language therapy works for people with dementia

Many people with dementia have difficulty with everyday conversations. They may also have problems with eating, drinking and swallowing. Sometimes these problems occur early on in the disease process. For others they may appear later.

Speech and language therapists (SLTs) work with people at all stages of dementia. They help people who have difficulty with everyday conversations and eating, drinking and swallowing difficulties.

This leaflet is for:

- people living with dementia
- families and carers
- health care staff
- social workers
- link workers
- home and social care staff
- advocacy workers

What SLTs do for people with dementia

Speech and language therapists enable and support the person with dementia and their carers to deal with communication and swallowing difficulties. They:

- Assess a person's communication and their eating, drinking and swallowing abilities and needs
- Provide 1-1 or group therapy to help the person and their carers maintain the best possible communication
- Provide personalised eating and drinking plans to help the person and their family make the most of mealtimes
- Provide training and practical resources to help communication and / or eating and drinking to anyone living with, working for or providing a service to the person and their family.

Levels of SLT service for people with dementia vary across the country. See overpage for information on **"How you can access speech and language therapy".**

The leaflet that Joy's team helped develop.

'We can help carers to manage eating and drinking safely, so that a person isn't at risk of coughing or developing a chest infection. For example we provide advice on posture, altering the texture of food so it's easier to swallow, or environmental factors like noise or low light.'

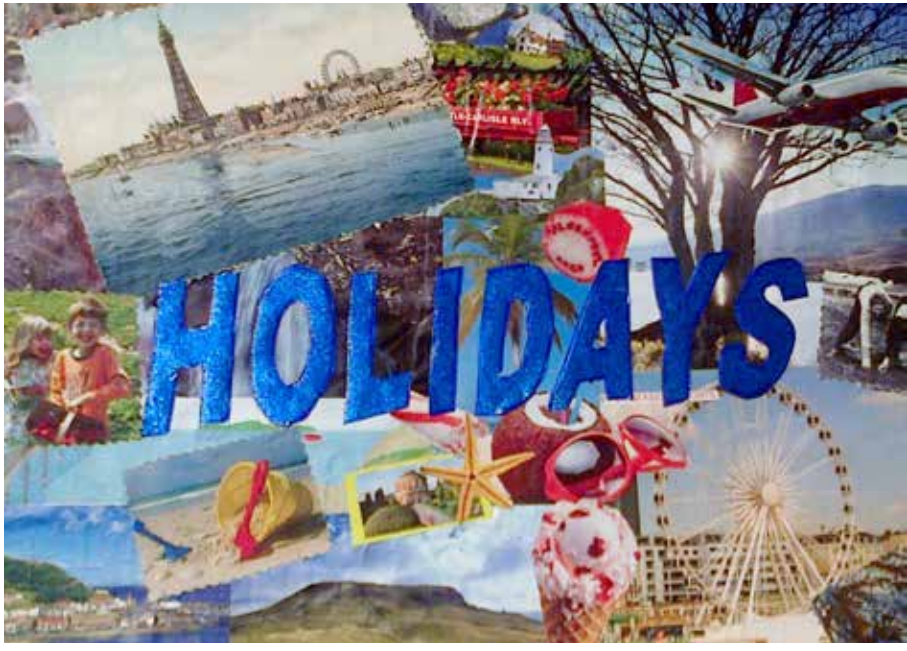
Working in partnership to support people with dementia in the community

Ruth Gardner is an occupational therapist based within NHS Forth Valley. As the team lead in a community mental health team for older adults, she and her AHP colleagues have worked on many projects to support people with dementia, including carers' groups, falls prevention work, and education around delirium.

I've been based in NHS Forth Valley since I began working here as a student 23 years ago. For 5 years, I have been the team lead for the Occupational Therapy community mental health team, with an overview of the varied work we deliver. We cover the whole of NHS Forth Valley, which includes Stirling, Falkirk and Clackmannanshire.

For the last year we have run a cognitive stimulation therapy (CST) group in Falkirk for people with dementia, and more recently we began offering a carers' group alongside this. Carers would often bring the person with dementia along to the formal CST group, and sometimes this brief meeting would be our only opportunity to talk with them. To address this, we created a dedicated CST support group, enabling carers to receive personalised support and learn how to deliver CST themselves at home. These sessions are led by a worker from the nearby Princess Royal Trust Carers' Centre.

In Stirling we helped the local charity Town Break set up a CST day-care service for people with dementia. Reminiscence therapy is included in Town Break's objectives, and they approached us for help with delivering the service. An occupational therapy assistant from my team trained a Town Break volunteer in CST, and now the charity provides the service independently.



A Cognitive Stimulation Therapy resource.

A major part of our service includes falls prevention work for people with dementia. Recently we implemented an innovative falls prevention programme called the Otago Exercise Programme, which was piloted in the Otago region

of New Zealand. This was developed for older adults, but we have adapted it for use specifically with people with dementia in the community.

The Otago Exercise Programme involves four visits to the person's home over two months, followed by monthly check-ins for a year. During the visits, a physiotherapist will teach the person with dementia various exercises which will help them maintain balance, and also improve their balance recovery. Exercises include using ankle weights and controlled breathing to help the person control their movements. After the face-to-face visits, the physiotherapist will provide monthly check-ups to ensure the person is managing their exercises independently, and to keep track of any falls or issues they may have. The programme has successfully helped many people with dementia improve their balance and stability.

I do a lot of work with carers and GPs regarding delirium, which goes hand in hand with the later stages of dementia. I'm a member of the Scottish Delirium Association, which aims to reduce the stigma surrounding delirium and inform people of how to manage it without medicine. I saw a man recently who had a delirious episode. He had been to his GP's out-of-hours service, and they had provided him with a leaflet we produced which helped him understand what had happened and how to manage it in the future. This was a positive inroad into dementia care, as there is little support around delirium, and now we are better prepared to deliver help for people who experience it.

These three community-based projects are just a few examples of the range of work we're doing to support people with dementia. By training others to independently deliver CST and falls prevention support, and raising awareness around delirium, our work is putting principles from the 8 Pillars Model of Community Support into practice on a daily basis. ■

'A major part of our service includes falls prevention work for people with dementia. We have implemented an innovative falls prevention programme called the Otago Exercise Programme.'

Left to right: Karen Dick, Alzheimer Scotland Link worker; Donna Maulder, Carers' Centre worker; Ruth Gardner; and Terri Schutten, Alzheimer Scotland Link Worker.

Introducing holistic and risk-assessed care into people's homes

Angela Pointon is an occupational therapist based within NHS Grampian. As a member of the Community Mental Health Team in Aberdeen City, she works with people throughout their dementia journey. The team's unique work helps people to remain independent in their homes by enabling them to overcome perceived risks and improving their environment.

Our team works with people with dementia at all stages of their journey and all care settings, and focuses on stimulating them and enabling them to continue to live a meaningful life. If people experience difficulties as their condition progresses, they are often referred back to us, and this is when our work follows the 8 Pillars Model of Community Support.

One of our main achievements is creating and implementing the Risk Enablement Framework. This helps people with dementia who are living at home to participate in activities that are important to them, even if there are perceived risks involved. We take an objective client-centred approach, looking at all elements of a person's life and using life story work (see page 10 – Gail Hogg) to learn more about them, what's important to them as an individual and use this to inform decisions about risk.

We have found that the framework can help carers view potential risks in a more positive way. Understandably, relatives will make a decision about a person's welfare purely based upon the level of risk that is present and not the value that the activity adds to the individual's quality of life. For example, we worked with a gentleman in sheltered housing who smoked quite heavily. A move into residential care was under discussion, which would necessitate him stopping smoking. Our risk enablement assessment found that stopping smoking or making other significant lifestyle changes may have introduced new risks that may have significantly impacted upon his quality of life. A big part of the process includes getting everybody – family, carers and professionals – around the table to discuss what is best for the person. Often this changes people's perspectives on

'our team works with people with dementia at all stages of their journey and focuses on enabling them to continue to live a meaningful life.'

which approaches will or won't work for a person with dementia.

A lot of our work follows on from this principle and centres on improving care and enhancing safety in a person's home. We do a lot of joint work with our local telecare department, recommending equipment which will improve people's home safety and quality of life. An example may be installing smoke alarms which link directly to a carer's contact number, alerting them immediately and automatically to any emergencies in the person's home.

A product we are regularly using is Just Checking. This is an automated system that records a person's routines and activities over a short period, using several passive infrared (PIR) movement sensors to detect movement throughout their house. We use this to assess routines and risks – for example we can assure a daughter that her mother is not likely to go out at night by herself – and also to tailor care packages to a specific person.

Just Checking is clearly useful for tailoring care and assessment, but we also use many other telecare and design features to turn homes into dementia-friendly environments. In our acute hospitals we carry out formal dementia design audits to improve the environment in terms of lighting, colour contrast and flooring.

We recently heard from a carer who had followed dementia design advice and implemented some of these design principles in her home. Her feedback on the changes was very positive. For example, her husband found it a lot easier to get around their home now that the lighting had been improved, cupboards were labelled, and new plain carpets had replaced the old patterned ones. Offering simple information and advice to people with dementia and their carers can have a huge impact, and we look forward to continuing to work with them in innovative ways to help them live a meaningful life in their own community. ■

Angela Pointon (third from left) with Hannah Dingwall, Michelle Dunne, Avril Verlegh, Serena Buchan and Helen Cronin. The poster represents the Risk Enablement Framework (shown in full on the facing page).

Helping male carers 'cook up a storm' for their partners

Elizabeth Stewart is the team lead for mental health dietitians in NHS Tayside. She helped organise a successful pilot project which taught male carers about cooking and nutrition, and providing for their loved one.

An important part of my team's responsibilities is to help people in the community learn about any aspect of diet and nutrition they need information on. We have a remit to support anyone who is in contact with older adult mental health services, which includes service users, carers, and public or third sector care staff.

Two years ago we were approached by Andy Bennett, a carers' support worker for the Rannoch Road Day Service in Perth. Andy had previously undertaken a needs assessment with male carers, which flagged up a need to improve their cooking skills. Their partners had traditionally been the household caretaker, and as the women's dementia developed, the men had to take up the role of 'chef'.

Andy made us aware that this was an issue for these men, and asked if we could offer some support. After a few meetings we came up with a proposal to provide sessions that would combine theoretical and practical aspects of diet and cooking. The goal was to equip the participants with basic cooking skills and also to teach them about nutrition. This linked to the 8 Pillars Model of Community support through assisting carers and personalising community care.

We called the project 'Cooking up a storm', and it ran for eight weekly sessions which were each two-and-a-half hours long. These included a half hour education element and two hours of practical cooking. The sessions were delivered by Andy Bennett, myself (or my colleague Elaine Pettifer in my stead), and Glenda McBeath, a cook from the Lewis Place Day Centre.

We tried to match the food in the practical part of the lesson with what we taught the men during the education session. For example, the first week was about eating well, so we explained why diet is so important to overall wellbeing,

Carers Bill Ferguson, Willie Robertson, Bill Rowan and Jack Harrison.

and made simple sauces which would add variety to meals, improve taste and add nutrition. The second, third and fourth weeks focused on the balancing act between starchy foods, protein and fruit and vegetables. We gave some common reasons for having a poor diet and how to avoid this, and helped the men cook stews, fish and puddings. In the later weeks we looked at barriers to eating well and the importance of being prepared. The final week consisted of enabling the male carers to choose what they wanted to cook using the skills they had learned.

The lessons were delivered in Perth and Kinross Council's North Inch Community Campus. We used a training kitchen that had several hobs and ovens, which was ideal for teaching people who were unfamiliar with cookery.

To assess the project, we provided evaluation questionnaires for the men to fill out in the second last week. We found that they struggled with creative learning techniques, having grown up with rote learning. If we were to run the course again, we would take this feedback into account. The men explained that their main focus was to gain or improve their cooking skills, as taking care of their partner was their first priority.

Feedback was generally positive. The men said that the mixed practical and theoretical nature of the lessons and the supportive environment was a good experience, with one man saying 'Cooking is not so frightening when you know how it is done'. We are looking forward to running the course again in future. ■

'After coming to our 'Cooking up a storm' session, one man said "Cooking isn't so frightening when you know how it is done"! '

Maintaining specialised community care through groups and carer support

Carol Mitchell is an occupational therapist who works in a community mental health team for older adults in NHS Ayrshire & Arran. Carol's innovative work with cognitive stimulation therapy (CST) focuses on community care and supporting carers to maintain CST themselves.

I have been working with this team for about five years, and prior to this I worked in younger adult mental health and social work. I was relatively new to working with people with dementia when I joined this multidisciplinary team, and I was interested in looking at national guidelines on dementia. It was through reviewing the SIGN and NICE guidelines that it became apparent that CST should be offered to people with dementia.

Our CST community group began in January 2014, and runs on an ongoing basis. I trained in the therapy in September 2012, and initially piloted it in an inpatient setting. We use the manual 'Making A Difference 2', which provides ideas for 24 group sessions, supported by a staff training DVD.

In cognitive stimulation therapy, we provide structured sessions based on reality orientation, reminiscence and sensory stimulation activities. The sessions start in a relaxed way, with introductions and name badges so that everyone knows each other's names. We then have a conversation around the day, date, weather and season. Newspapers are passed around and read, and we ask people to share a good news story with the group. After this we move onto the main activity which is different every week. For example, different sessions cover life stories, current affairs, and reminiscence around food or household objects. In the first session the group participants choose the name for the group as well as a theme song which we sing every week.

After we finished the group this year, we evaluated it using several tools. The Quality of Life in Alzheimer's Disease (QOL-AD) measurement tool showed improvements in many areas, including mood, memory and overall quality of life. We also used an occupational therapists' measurement tool before and after the group: the Model of Human Occupation

'The therapeutic benefits of cognitive stimulation therapy tie directly to the 8 Pillars Model.'

A CST maintenance group. (Consent for photographs held by Carol Mitchell, NHS Ayrshire & Arran.)

Screening Tool (MOHOST). This found main improvements in processing skills like planning, problem solving, and motivation.

We have received positive informal feedback on this group. One charge nurse referred a man who used to be very quiet, and after the sessions his wife said he was far more chatty and alert. Another woman was referred by a speech and language therapist when her communication skills were steadily declining, but after her CST sessions she showed a marked improvement in language tests. The therapeutic benefits of CST tie directly to the 8 Pillars Model of Community Support.

Many members of our community CST group become very attached to it. During the last session they often said things like, 'I can't believe this is coming to an end'. While we can't provide ongoing formal sessions after the course has ended, we have set up an informal group, run in tandem with Voluntary Action South Ayrshire, so participants still have something to look forward to.

We have also taken steps to ensure that people who come to our groups can maintain the benefits from the group at home. In order to do this we invite the carers to an information session following the last week of the CST group to advise them on how to support the person they care for using the CST approach at home. We are also developing a booklet which suggests 19 different themes with various activity ideas to help carers with this.

It is important that our care is personalised, provided in the community, and supportive of carers. The work we are doing to support people with dementia ties in with many aspects of the 8 Pillars Model of Community Support. We are looking forward to developing it over the coming year. ■

A CST group being facilitated by staff-members Jackie Martin, Pauline Rourke and Annie Dunlop.

Developing personalised art therapy for people with dementia

Claudine Albert is an art therapist working in the third sector in Edinburgh. She has worked with people who have a diagnosis of dementia in community and care home settings for several years, and was one of the founders of the Edinburgh Art Therapy Centre.

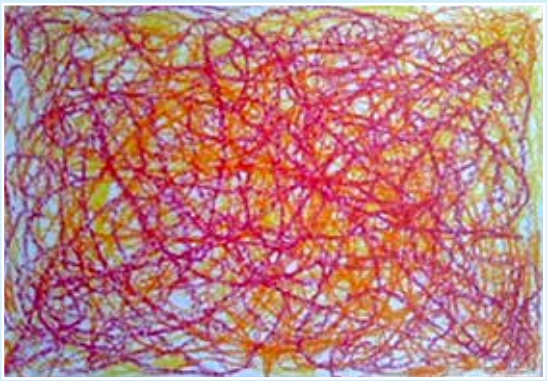
Between 2011 and 2014 I was involved in setting up and running a third sector organisation called the Edinburgh Art Therapy Centre. We ran various projects but the most successful ones involved our work in dementia care. This began in partnership with a day care service for people with dementia, but grew to provide more opportunities for supporting our community.

The project grew out of an initial six month art therapy group for members of the dementia day care service held at Edinburgh's Eric Liddell Centre. I started this group in 2011 and it was attended by six people who were living independently in the community at that time.

Over the course of the sessions I closely monitored and evaluated the changes in participants' moods and responses to the therapy. We used the results of these evaluations to apply for funding which was granted by Edinburgh Council Neighbourhood Partnership. This led to a six month extension of the project, enabling us to offer our art therapy service to anyone in the community living with dementia.

We maintained our previous links with the Eric Liddell Centre, but the service was expanded to encompass several other sites. These included The Elms – a designated dementia care home – and the acute wards of North Merchiston Care Home in Edinburgh. Both of these support people in the later stages of dementia. We also received some referrals from NHS Lothian's Community Mental Health Team Older People's service and I was able to work with a gentleman in his home environment through this.

Funding for this work was short-term, but following a further application we received support from the Scottish Government's Third Sector Resilience Fund. This enabled us to employ three more art therapists, to increase our ward coverage in North Merchiston Care Home, and establish a Saturday art therapy group in collaboration with The Open Door, a charity located in south Edinburgh. When Portobello started working towards becoming a dementia-friendly community, we also set up another weekly art therapy



group for that area, which ran for a further six months for people with a diagnosis of dementia and their carers.

We use art as a form of psychotherapy, rather than purely as an activity. Art therapy involves working with people at an unconscious level, focusing on the process of them making art rather than what they produce. This involves observing whether they work with energy or lethargy and supporting them with any difficulties they may have, either with the materials they use, or in the feelings brought up by their images. We find that it gives people a safe space to explore their feelings and reduces the sense of isolation they may feel with dementia. This therapy has previously been equally beneficial for carers.

In the later stages of the condition, we move away from group work. The boundaries for people with advanced dementia are very different, and they may feel a lot more anxiety and confusion. At this stage, our work focuses on the moment. For example, we may come in with a colourful basket of various materials that are suitable for sensory stimulation. Extraordinary insights can result, and this is art therapy at its most rewarding.

Funding for the Edinburgh Art Therapy Centre came to an end earlier this year. However, we feel confident that the centre succeeded in providing personalised and therapeutic care for the last three years, linking in with several core principles of the 8 Pillars Model of Community Support. We are hopeful that there will be opportunities to launch a similar service again in the future. ■

'Art therapy involves working with people at an unconscious level, focusing on the process of them making art rather than what they produce.'

Improving quality of life in care homes through partnership working

Lynn Flannigan is a physiotherapist based within NHS Lanarkshire. In the last year she has played a key role in piloting the Up and About In Care Homes and local Football Reminiscence projects. These are helping to improve the care home environment for people with dementia in various ways.

I've been a physiotherapist for 22 years, and have worked in many care settings. Most recently I have been in post as a care home liaison in Lanarkshire, where the vast majority of the people in care homes have a diagnosis of dementia. Since 2012, I have worked on two hugely beneficial projects: the Up and About In Care Homes programme with the Scottish Government, and the Football Reminiscence project in partnership with Alzheimer Scotland.

Our successful work on the Football Reminiscence project was the result of close partnership working between several organisations. These include NHS Lanarkshire, Alzheimer Scotland and a three private Balmer care homes. The care homes began hosting a Football Reminiscence group, with support from the University of the West of Scotland. We worked with Alzheimer Scotland Football Reminiscence Facilitator Norrie Gallagher to deliver these sessions for men in the home.

Traditionally, care home activities have a more female focus, and the Football Reminiscence group has given men a chance to create their own space and enjoy their old pastimes. The men have their own song, their own team name, talk about football and share personal memorabilia. One man hadn't left his room since arriving at the care home, but after attending the group he became animated and chatty.

Over the last eight months, I have started working on the Up and About In Care Homes project as deputy project lead. This project aims to reduce the number of falls in care homes across Scotland, and is funded by the Scottish Government as part of the National Falls Programme.

People with dementia are significantly more likely to fall than people of the same age without a diagnosis. After we identified this high risk factor, various agencies including Alzheimer Scotland began working towards improving the NHS Scotland care pathway relating to falls and dementia.

To do this we supported care homes to examine their environment in terms of being dementia- and falls- friendly. Many of the improvements which help prevent falls are also beneficial to people with dementia in general. They include improved lighting, greater levels of contrast, increased signposting and the removal of trip hazards. This work has

'Traditionally, care home activities have a more female focus, and the Football Reminiscence group has given men a chance to create their own space and enjoy their old pastimes.'

Lynn Flannigan (right) with Margaret Kelly, a member of staff at Langcraigs Care Home.

led to the development of leaflets and resources for care home staff with advice on improving mobility and independence for residents with dementia, whilst reducing their risk of falling.

We liaised with staff across Scotland to produce these resources, in particular the three partnership areas we piloted the project in (West Dunbartonshire, Dumfries & Galloway, and North Highland). We have also worked in tandem with many agencies in delivering the project. For example, we helped an occupational therapist from NHS Lanarkshire produce and distribute a leaflet on seating. I have worked closely with two of Alzheimer Scotland's Dementia Advisors, Lorna Hart and James McStay, who have provided advice and information on dementia. I have developed resources on Meaningful Activity and chair based exercise in partnership with a colleague from Alzheimer Scotland, Anne McWhinnie.

Our evaluation of both of these projects has demonstrated a significant improvement in quality of life for people with dementia in care homes. Up and About In Care Homes has also seen significant success: Lynda Forrest, an occupational therapist in NHS Highland (see page 6) told us about a man who would often fall up to four times a week. Since they introduced our resource, he no longer falls at all. We look forward to sharing our resources more widely and developing these services further in the future. ■

Tailoring partnership work for people with dementia in the community

Pasna Sallis is an occupational therapist based within the new Young Onset Dementia Service in NHS Greater Glasgow and Clyde. This post diagnostic service works collaboratively with community mental health teams and closely with Alzheimer Scotland in community and hospital settings. Her work brings together adults with young onset dementia and their families to live well in their communities.

My work involves supporting the person with dementia and the family member. For example, I worked with one woman in her early 50s, who could no longer drive the car because of her dementia. She depended on her husband for lifts to/from local community groups. This led to her reduced self-esteem and dignity, as she was previously very independent. Inevitably, this also had an impact on her husband as he had limited opportunity to pursue his career.

Following my assessment, findings suggested she had potential to learn new skills. We identified that she was able to use taxis independently, so a graded activity support plan was devised with her and her husband, to promote self-management. Partnership work was undertaken with a local taxi firm to personalise the plan to meet her needs. Following this intervention, this woman was able to use the taxi service independently and learnt further skills to be able to order a taxi too. She expressed feeling 'brave' afterwards and went on to use the taxi service more spontaneously, for example to visit her frail mother and to go shopping when she felt like it. Her husband now has more free time to engage with his career tasks.

One of our unique strengths is that occupational therapists make assessments in the person's real-life context, in their workplace or community. For instance, I have been working with a person who continues to play tennis passionately despite his diagnosis of dementia (pictured right wearing the yellow shirt). His family have been instrumental in providing support at home and opportunities to play tennis with others. He is currently the Scottish champion in his age group for tennis. His tennis coaching career ended upon his diagnosis, but his father was keen for him to continue to contribute positively to society. He suggested exploring his son's potential to engage in the role of 'hitting partner', an emerging field in tennis. I undertook a series of assessments at tennis courts and findings suggested that this role could be a possibility for him. I devised an enablement plan which suggested ways to manage current communication and behavioural challenges for him when playing tennis. This plan was agreed in partnership with

'I have been working with a person who continues to play tennis passionately despite his diagnosis of dementia.'

his family, a leading tennis coach and club manager, and potential pupils. This meant he could pursue a vocational role despite his diagnosis.

As occupational therapists, we can bring about transformational change and leadership as we work across traditional boundaries. An example of this work is a lady in her early 40s with whom I am working who has been in a long stay elderly ward for over a year. Her family are keen for her to take part in more age-appropriate community groups as a way of improving her quality of life. Following my assessment, I was able to identify a suitable community activity group. This was run by a voluntary organisation which is not traditionally associated with people with dementia. However, in this case, the community group was able to meet her needs and to engage in community based leisure activities that are meaningful to her. I created a risk enablement plan to support this lady in attending the activity group, made in partnership with the family, Alzheimer Scotland staff, ward staff and a non-traditional voluntary agency. This multidisciplinary team in conjunction with social work staff is exploring an alternative to care home placement, as my occupational therapy findings suggest that she has the potential to reside in community supported accommodation. ■

'As occupational therapists, we can bring about transformational change and leadership as we work across traditional boundaries.'

Developing evidenced-based policy for Allied Health Professionals

Elaine Hunter is the National Allied Health Professions Consultant based in Alzheimer Scotland. Her role focuses on bringing the skills of AHPs to the forefront of dementia practice and linking this to the needs of people with dementia and their carers, partners and families.

This is the last publication in our suite of three AHP dementia reports where we have shared some of the innovative work that allied health professionals are doing in Scotland to support people with dementia, their partners, carers and families. All three will inform the work I am leading on, on behalf of Alzheimer Scotland, to deliver commitment 4 of Scotland's National Dementia Strategy 2013–16:

> *We will commission Alzheimer Scotland to produce an evidence based policy document outlining the contributions of AHPs to ensuring the implementation of the 8 pillar model. (Scottish Government 2013)*

The AHP commitment in Scotland's Dementia Strategy is an important lever for change and improvement, with allied health professionals being offered an opportunity to be transformational and to enhance access to allied health professionals' knowledge, skills and expertise. When developed, the policy document will be of interest to the 11,197 allied health professional colleagues working in acute and primary care settings across NHS Scotland (ISD June 2014), and our 500 AHP practitioners in social care who are predominately occupational therapists (Scottish Government 2012:6).

Over the next six months we will continue to map our contribution to the Alzheimer Scotland policy work around the 5 and 8 Pillars Models and the developing work on advanced dementia. The Alzheimer Scotland models offer allied

'We will continue to map our contribution to the Alzheimer Scotland policy work around the 5 and 8 Pillars Models and the developing work on advanced dementia.'

Scottish Health Awards 2014. Quality Champion of the Year Award: AHP Dementia Champion, Jennifer Taggart, NHS Greater Glasgow and Clyde.

health professions a way to articulate the contribution of AHP-led dementia-specific therapies for people living with dementia, with the aim of promoting resilience, enhancing coping, maximising independence and improving quality of life, whilst also working with carers.

Key to any policy development is the desire to engage people living with dementia, their carers, families and partners. We are doing this in a number of ways, working closely with the Scottish Dementia Working Group and the National Dementia Carers Action Network. We will also be connecting with people living with dementia and carers by travelling to where they are and having individual conversations in Alzheimer Scotland dementia cafés and resource centres. We have looked to social media to engage with people too, launching the blog 'Let's Talk about Dementia' (www.alzscot.org/talking_dementia) in June 2014. The blog is hosted and supported by Alzheimer Scotland and led by allied health professionals. We are engaging with people living with dementia and carers through this blog, receiving comments on blog posts and beginning to see which AHP-led interventions are important to them.

We are building the foundations for a policy document for allied health professionals that is inclusive and engaging, whilst acknowledging the importance of partnership working with our colleagues in the NHS, local authority, higher education institutions, the third sector and many others. Allied health professionals have much to offer people to live well with dementia. All three publications in this series illustrate what a difference their work can make to a person living with dementia, along with their carers. ■

Scotland's Dementia Awards 2014: Best Acute Care Initiative. 'Pocket Ideas … for a moment in time', NHS Ayrshire & Arran.

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AHP family supporting Alzheimer Memory Walk, Lochore Meadows September 2014.

This publication is the third in a series of three reports sharing examples of the innovative work that allied health professionals are doing in Scotland to support people with dementia, their partners, carers and families. Much of this work is being actively supported by Alzheimer Scotland.

Alzheimer Scotland wants to make sure nobody faces dementia alone. There are two main objectives that help us achieve this and drive all our work:

- being the foremost provider of support services and information for people with dementia, their families and friends throughout Scotland
- being the leading force for change at all levels of society, protecting and promoting the rights of people with dementia, their families and friends.

Alzheimer Scotland is committed to improving the lives and opportunities of people with dementia, their partners, families and carers. We do this through provision of direct support services, and by raising funds to provide our 24 hour Freephone Dementia Helpline (0808 808 3000), our networks of Dementia Advisors and Dementia Nurses, and our Dementia Research Centre. Our work and campaigning activity is informed by our 7,000 members and delivered by over 1,100 staff and 700 volunteers.

For more information about who we are and what we do, visit www.alzscot.org

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